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Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

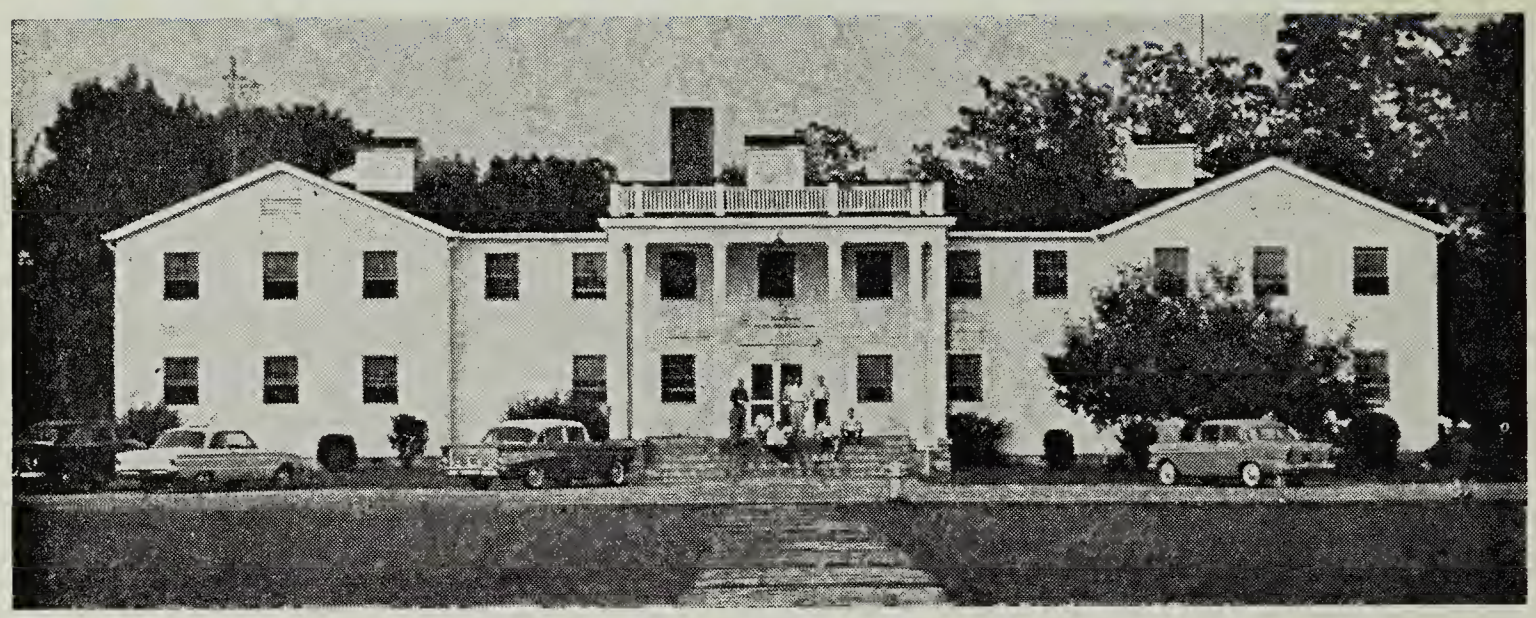
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $120 is payable at the time of admission. Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

R. J. BLACKLEY, M.D.
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Success hinges on the degree to which public attitudes are changed.

A Community-Oriented Approach to Alcohol-Related Problems

BY S. GEORGE CLARKE

DIRECTOR OF COMMUNITY SERVICES
FLORIDA ALCOHOLIC REHABILITATION PROGRAM

Reprinted from the *Reporter,* a publication of the State of Florida Alcoholic Rehabilitation Program.

STATISTICS can be frightening—if we take them seriously!

For example: there are at least 180 thousand alcoholics in the State of Florida. The number is increasing at the rate of 10 thousand a year. It would take 90 years for the State's facilties to treat the present number. The same hospital and clinics, ignoring the present alcoholic population and concentrating exclusively on the increase, could reach only one out of five. All resources, public and private combined, are probably treating less than five per cent of them.

Now, these statistics are basically correct. Furthermore, the awful magnitude and baffling complexity of the impact of alcoholism on our society is just beginning to be recognized. Still another dimension of gloom may be added by noting, with equal certitude, that the long-term rehabilitation rate continues to be appallingly low.

In the face of these facts, one may become cynically calloused, or rush out with confused concern to open vast new treatment centers—which probably could not be filled. Or, barring these alternatives, he could shed the appropriate number of tears and reach for the nearest bottle!

The Community Services Section of the state program operates on the premise that there is a more practical approach. Underlying this assumption, are the belief that most of the needed treatment facilities either already exist or are in the planning state, and that training, cooperation, and massive public information are the keys.

A community-oriented approach, then, begins by facing up to the full implication of two facts:

1. Alcoholism is a progressive disease, normally taking 8-20 years to develop, and is marked by clearly discernible "warning signals." 2. The basic reason for the low rate of recovery is that most alcoholics do not seek treatment until very late in the progress of the disease.

The striking parallel between this fourth public health problem and the number one problem, cancer, is both obvious and suggestive. Thirty years ago, fewer than twenty out of each hundred cancer patients survived. Ten years later, the number had risen to twenty-five. Today the figure is at least thirty-five—and, although American Cancer Society officials don't publicly claim it, many feel privately that fifty is a more accurate figure.

It is of utmost significance that

this dramatic saving of human life has come about not primarily through improved techniques, but as a result of a tremendously successful public education program about the danger signals of cancer. This has resulted in patients seeking treatment at an earlier stage in the progression of the disease.

As has already been noted, alcoholism, too, is a progressive disease. It seems reasonable to assume that the possibility of rehabiltating the alcoholic in the prodromal and early alcoholic phase is far greater than if he does not come to treatment until he reaches the crucial or chronic phase.

The first step, then, in a comprehensive attack on alcoholism, should be a well-conceived and massive program of education, aimed at acquainting the total community with such danger signals as: use of alcohol as a drug instead of a beverage, increased tissue tolerance to alcohol, blackouts, "sneaking" drinks, loss of control, overuse of certain defense mechanisms (denial, rationalization, projections), characteristic personality traits—to name some of them.

While it is true that some additional facilities would be needed for diagnosis and treatment, it would be emphasized that opening the doors (which lingering misinformation have kept closed) of existing institutions is far more basic. Concurrently, a program of professional education, designed to share the knowledge of alcoholic rehabilitation therapists with related disciplines, must be vigorously pursued.

While vigorously stimulating and coordinating treatment opportunities, parallel efforts should be underway, aimed at prevention of the illness. In a clinical sense, we cannot correctly speak in terms of prevention because we still have not been able to identify the cause. However, there do seem to be certain unhealthy family relationships and personality traits that predispose individuals toward alcoholism. While it is true that many having these characteristics do not become alcoholics, practically all alcoholics do have them. A positive program of alcohol-alcoholism education in our public schools would be a step in the right direction.

Ultimately, however, success hinges on the degree to which public attitudes can be changed. Marked progress has been made. Much of the ignorance, disdain, and pseudo-morality have already been left behind. Yet no one denies that the longer leg of the journey still remains.

Probably the best hope lies in voluntary citizen groups, communicating with one another through a volunteer statewide association. Such groups should be autonomous. But, while free of State control, it is absolutely imperative that there be a close and continuing cooperation between the State agency and the private volunteer groups. Thus, the tax-supported, government-controlled program can function in those areas for which it is uniquely fitted, and the local alcoholism programs and their state association can perform those services best rendered by non-government, citizen effort.

The foregoing outline briefly sketches what are the continuing goals of the ARP's Community Services Section. Its statewide staff and regional field representatives are striving to multiply their own limited outreach by being primarily the catalysts that stimulate, guide, and coordinate the numerous existing and emerging resources. They are working closely with the seven countywide citizen groups already operating and are actively promoting the organization of many more.

Librarian Writes

We wish to place a subscription for the publication, *Inventory,* and would like to obtain back issues of this periodical if available.

Mrs. Anne S. Briley
Periodicals Librarian
East Carolina College
Greenville, N. C.

Does Alcoholism Research

I would appreciate being put on your mailing list for *Inventory,* and am especially anxious to obtain a copy of Vol. 16, No. 1 (July-Sept., 1966).

I am an anthropologist who is working to a large extent on the socio-cultural aspects of alcoholism. I am currently writing up, in book form, the results of a year's research on Alcoholics Anonymous as a subsociety. This work was done in the California Bay Area under the auspices of the Institute for the Study of Human Problems at Stanford University. In the near future I hope to take the first steps in inaugurating an investigation of the particular problems of Mexican-American alcoholics.

William Madsen
Professor of Anthropology
University of California
Santa Barbara, California

Helpful to Physician

Recently I read a copy of your publication, *Inventory.* As an alcoholic I found this a very helpful book in maintaining my own sobriety. As a physician who treats other alcoholics I feel that it will also help me to help others to maintain sobriety. Could I be placed on your mailing list?

Anonymous
An Alabama Town

Considering Pilot Project

Please place us on your subscription list. We are considering a pilot project for the Bowery here in New York.

I am especially interested in an article in Vol. 16, No. 1 which I read while in the office of some public health people in Seattle Washington. They recommended your publication highly.

Vera Institute of Justice
New York, N. Y.

Helpful to Probation Officer

Would appreciate your placing my name on your mailing list for *Inventory.* I do work with persons who have drinking problems and any material that you may forward will be helpful.

John R. Brady
State Probation Officer
Jackson, N. C.

For Use in Nursing Class

I thought Dr. Gordon Bell's article "Chemical Comforts" was very good. If you have additional copies I could well use them for my class in advanced medical-surgical nursing. We are considering problems of alcoholism early in January.

Sister M. Louis
Associate Professor in Nursing
Marquette University
Milwaukee, Wisconsin

VOL. 16, NO. 3 INVENTORY JANUARY-MARCH, 1967

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

CONSTRUCTIVE COERCION AND GROUP COUNSELING in the Rehabilitation of Alcoholics

BY EDWARD W. SODEN

PROBATION OFFICER
UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

As probation and parole officers we must recognize that there is tremendous therapy in the constructive and intelligent use of authority—constructive coercion.

This article is reprinted from the September 1966 issue of *Federal Probation*. Mr. Soden was formerly supervisor of the Alcoholic Rehabilitation Unit of the Probation Department for the District of Columbia Court of General Sessions.

THE time has come when we as probation and parole officers must realize the problem of alcoholism (uncontrolled drinking) is the Nation's third most serious health problem. It is so serious and so deeply entwined in the myriad problems of probationers and parolees that we can no longer be content with merely being aware of its prevalence as a problem. The fact is that we as probation and parole officers are obliged to be concerned about the problem and, more important, to do something about it.

Alcoholism

Before discussing constructive coercion and motivation, it is necessary that there be some explanation of certain simple facts relating to alcoholism and the alcoholic.

The problem of alcoholism, with us since time immemorial, has grown to gigantic proportions and continues to grow at an alarming rate. The seriousness of the problem is best emphasized by the statement made a few years ago by Dr. Karl Menninger who said, "If alcoholism were a communicable disease, a state of national emergency would be declared."

In 1956 alcoholism was acknowl-

edged as a disease by the American Medical Association. It is an ailment or condition in which physical and mental health are impaired. Although a self-inflicted disease, and not curable, it may be arrested. Once the "habit" of sobriety has been achieved, then eternal vigilance must be maintained against relapse. It must not be forgotten that the alcoholic will have this problem for the remainder of his life. In other words, "once an alcoholic, always an alcoholic." He either stays away from alcohol *completely* or suffers all the disastrous consequences associated with its continued use.

Alcoholism is a disease that is not readily apparent in its early stages. Of all diseases, it is the one most likely to be mislabeled, to be denied, to be hidden. Too often it is not recognized by others or admitted by the victim until it has grown to such proportions that it can no longer be denied.

When a person begins drinking there is no way to foretell whether he will become an alcoholic. Anyone who drinks is a potential victim of alcoholism.

Alcoholism has been stigmatized because the public has made it something which people hesitate to talk about. Once people are sufficiently informed so as not to hesitate to admit and to discuss their alcohol problem then, and only then, will we be able to accomplish a great deal more in the treatment of alcoholism.

Over the years I have been privileged to lecture and conduct programs and workshops on alcoholic rehabilitation at various courts, probation and parole training institutes, seminars, and university schools of alcohol studies. I also have been privileged to have a part in assisting with the establishment of alcoholic rehabilitation programs in several courts and probation departments.

In studying and discussing this problem with court and institutional officials around the country, it has not been surprising to hear some probation and parole officers categorically state that alcoholism is a serious problem in their caseloads and that conservative estimates run from 50 to 75 percent. Without qualification many of them have said that uncontrolled drinking is a major problem in their caseloads.

Historically, drunkenness has been a social malady which existed before any written history of mankind. It was first considered an individual moral problem but because each drunken offender affected so many others, it soon came to be treated as an offense against society. There were those who argued that it was a spiritual problem, others who proclaimed it a health menace.

Years ago, society punished the drunk with the ducking stool, the lash, the public cage and stocks; and on occasion, even went so far as to pour molten lead down his throat.

Use of Constructive Coercion

In discussing constructive coercion and motivation, it is important to understand that in most cases the alcoholic is the last person to admit a drinking problem. It would be a mistake to assume that most alcoholics who first attended Alcoholics Anonymous meetings or sought help through medical or other channels, did so voluntarily.

It is most unusual when the alcoholic has not been coerced in one way or another into seeking help for his problem. The doctor has intimated that death would be inevitable; the psychiatrist has implied that insanity will result; the clergyman has said that the end will be disastrous; the wife has threatened

to leave or has already left; the boss has either fired him or has threatened to do so; the community has branded him a drunk. Or he has become so disgusted with himself that he has lost his self-respect. As a final desperate measure, he seeks help. Often there is no sincere or realistic desire to find help or to be helped. He seeks help only to relieve the pressures which are bearing down on him and to "take the heat off."

Constructive coercion can hardly be challenged if it will bring about a change in thinking that will result in the person's doing something about his problem. Considering the harm caused by alcoholism to the person himself, to his family and to society in general, it is difficult to understand why there would be opposition to the use of constructive coercion in the field of corrections when in reality, circumstances resulting from uncontrolled drinking have actually coerced the individual into seeking or at least giving "lip service" to something of a solution to a critical problem.

Is there any "bad way" to bring a person to his senses? Is there any bad way to help a person accept the fact that he has problems? There is usually no hesitancy on the part of the probation or parole officer to insist that a reluctant person take treatment for venereal disease or tuberculosis. Yet, there often is a hesitancy about enforcing treatment upon alcoholics. Much of the reluctance in the latter case often is due to the lack of knowledge of supervising probation and parole officers in detecting the problem, or if the problem is detected, knowing what to do about it. Reluctant as the individual may be, there is always that strong possibility that exposure to information about his problem and the avenues of help available to him will result in a "breakthrough."

While there is much that has been said in connection with the phrase "you can lead a horse to water but you cannot make him drink," it is contended that there is much which can be done to expose the problem drinker to sources of help.

Coercion has been used successfully in alcoholic rehabilitation programs in industry, in penal and correctional institutions and in courts and hospitals. Why, then, is coercion ignored in probation and parole? As probation and parole officers, we must recognize that there is tremendous therapy in the constructive and intelligent use of authority—constructive coercion.

Group therapy for alcoholic probationers and parolees on a voluntary attendance basis usually insures that those persons who are really interested do attend. However, experience has shown that in such voluntary programs there are many who do not attend. This would suggest that the efforts extended do have value, but only for a few. Therefore, it is contended that compulsory attendance (constructive coercion) is necessary if a program is to be effective and is to have value. It is contended, moreover, that exposure can be beneficial even if only by the "power of example" displayed by those attending the meetings who have met with success in helping themselves.

Let us not forget that rehabilitation of the alcoholic goes far beyond the first step of helping him to function as a sober person. It is also absolutely essential to help him take an active part in the community in which he lives. Our work is most important in the area of salvaging human beings, homes and families. It is impossible to place a monetary value on the return of a person's

self-respect and human dignity.

Group counseling is two-fold in purpose. The individual finds that he is not alone in his problem, and that he can communicate with others in a like situation, in a sober condition, and on realistic grounds. He also finds that he can return to the community relieved of guilt and that he can look forward to the future with a confidence born of an understanding of his problem and what to do about it.

To say that a person with a drinking problem is unmotivated would appear to be an easy method of evading our responsibility as probation and parole officers. The alcoholic's difficulty in acknowledging that he has a problem and his reluctance to seek help is all part of the alcoholic pattern. The lack of acknowledgement of his problem and his reluctance to seek help are often significant detectable symptoms which must not be overlooked. Only a small proportion of all alcoholics are known to specialized alcoholic treatment programs, services, and to Alcoholics Anonymous. However, it is not too difficult to detect cases of alcoholism if the officer is aware of simple detectable symptoms.

Motivation

We, in the field of probation and parole, often have found that as helping persons we are able to recognize that those persons who sincerely want to do better do so more readily than those whose attitude is negative or indifferent. The well-motivated person really helps himself; the probation and parole officer sets the guidelines, in the hope that the alcoholic will be motivated to help himself.

Rather than telling a person that there is nothing that can be done for him until he is genuinely motivated, it is the responsibility of the parole and probation officer to use his experience, skills, and abilities to create motivation and to guide the person toward a new understanding of himself and his responsibilities.

There is much hogwash about the need for positive motivation as a prerequisite for helping the alcoholic. To refuse to help an unmotivated probationer or parolee until he is ready to accept the terms laid down to him by the probation officer is comparable to an admission of failure on the part of that officer. Actually, the person who is not highly motivated, who is doubtful as to whether he is an alcoholic, who is still floundering, is the one who needs help more so than the person who is "properly" motivated. To be responsible to our profession we probation and parole officers must not select only those with whom we feel we can be successful. We must double our efforts with those who are not motivated. It is our responsibility as probation and parole officers to do all we can to help the individual help himself to become an asset to society rather than a liability.

The use of authority and motivation has long been recognized as a valuable treatment tool in probation and parole. It is not the function of probation and parole to free the individual from all limitations, but rather to help him to understand and accept the realities of his situation.

It often has been stated that a client must willingly accept a service rather than having the service imposed upon him. The offender does not seek probation or parole in order to conform to accepted community standards. The use of authority is essential to instill in the offender a respect for law and constitued authority.

One of the important goals of constructive coercion is to give the alcoholic insight into his problem, to show him his need for help, and then hopefully to motivate him to want to receive and utilize that help.

How to motivate the alcoholic probationer and parolee is a difficult problem. A significant start will have been made if the supervising officer acts decisively, making use of early signs of detectable symptoms, and directs (constructive coercion) the individual to share his problem with a treatment facility.

In our office the treatment facility is the Alcoholic Counseling Group. Obviously, all incentive for the alcoholic to seek and accept help cannot come from just being on probation or parole, but it can play an important role.

Group Counseling Program

Six years ago a program of group counseling was established in the United States District Court for the District of Columbia under the direction of Edward W. Garrett, chief probation officer, now retired. The program is being continued by George W. Howard, his successor who was formerly deputy chief probation officer for many years. The program started out on the premise that the traditional methods of supervision needed to be complemented with other techniques and devices if the alcoholic probationer and parolee was to have a more favorable adjustment in the community. The program has been altered and expanded over the years. Today it consists of several different task - oriented groups.

At present two basic types of groups are in operation—the "orientation group" and the "continued treatment group." With but few exceptions, each person received for supervision on probation, parole, military parole and mandatory release is placed in an orientation group as quickly as possible, hopefully within a week or 10 days. The orientation group consists of four weekly sessions, attendance is mandatory (constructive coercion), and its goals are simple. They include encouraging the individual to use his period of supervision productively and to benefit from group interaction.

Much experience and knowledge have been gained. The orientation group now is also used to observe the person within the group setting. Every effort is made to detect emotional and behavioral problems for the purpose of planning a program of treatment.

When the orientation group period is completed, a classification committee, consisting of the probation officer, the field officer assigned to the case, the orientation group leader, the group observer, and the chairman, makes a determination as to what treatment should be recommended in the best interest of the respective persons.

The "continued treatment" groups have a variety of goals and purposes. Some groups offer supportive type treatment; others offer intensive treatment. The family group offers help with problems of family relationships and another focuses on employment problems. One officer is experimenting with operant conditioning in his caseload.

Alcoholic Counseling Group

The alcoholic counseling group was formed in March 1965. A definite need existed for such a group. The goals of the group program are basic and simple—to give hope, understanding, help, and to make other resources available.

The specific purpose of the group is to stimulate and change thinking patterns and increase knowledge and understanding. Knowledge is more meaningful and lasting if it can be talked about and shared with others.

Other purposes of the group are to help develop insight, to achieve possible personality changes, to develop independent and mature relationships, and to assist in establishing goals that are realistic to the individual. Attitudes are reexamined, discussed and modified.

As one sees a fellow group member sincerely trying to understand his problem and discussing it honestly, the stimulation often becomes contagious. It can be the means of exciting and spurring others into trying.

In addition to those assigned to the alcoholic counseling group by the classification committee, others are directed to attend the group as a special condition of probation. In other instances, a person may be assigned to the group when a developing drinking problem is detected by the probation officer.

It is my conviction that those with known drinking problems who are placed on probation or released from penal institutions for supervision, should be exposed to group counseling immediately; they are more amenable, at that time, than those who have been under supervision for several months. The sooner the exposure to group counseling therapy the more profitable and beneficial will the experience be to the individual.

On a recent occasion the greater part of a staff meeting was devoted to discussing the problems of alcoholism and its effects, not only on the individual, but also on the family, the employer, and the community. Also stressed was the importance of being aware of simple detectable symptoms, including frequent absenteeism from work (especially on Mondays), personality changes when drinking, reporting while under the influence of alcohol, and arrests for being drunk.

The present group format is as follows:

1. Group discussion is encouraged in reference to alcoholism as a disease, its progressiveness and many attendant problems, with emphasis on it being arrestable but not curable and that the only solution is complete abstinence.

2. Individuals are urged to select pertinent topics in which they are interested and concerned. These are discussed in depth.

3. Educational films are shown frequently and are selected carefully for their content and value. Usually they depict and discuss the social, psychological, and physical aspects of the problem. Case histories are presented and discussed. Avenues of available help are often the climax of the films.

4. Selected A. A. speakers discuss their experiences and the help they received through Alcoholics Anonymous. A question-and-answer period follows. All are constantly urged to seek the help which is available through A.A. A.A. literature is distributed at no cost.

5. Staff members from community resource agencies are invited to discuss their programs and the help their agencies render.

Basically, the program is geared to and oriented toward the specific problems and needs of the alcoholic. It attempts to make those with a drinking involvement aware of that problem, its seriousness, and its progressive nature. With this knowledge they then will be hopefully motivated to seek help with their problem

and, more important, to help themselves.

Change in Program Format

Upon the completion of 21 weekly meetings of the first group, an evaluation was made and the program format was reorganized. The meeting place was changed from an office used by a supervising officer to a larger conference room. Noticeable interest was created by this change from an official atmosphere to one that is more relaxed with comfortable arm chairs and no lock. A large conference table, around which all had previously sat, was removed. Instead of providing a relaxed and comfortable seating arrangement, it actually created a psychological barrier. A circle of comfortable arm chairs, with smoking permitted, has been found to be more conducive to an atmosphere of relaxed and easy discussion.

All are apprised of the confidentiality of the discussion but are also alerted that it is the obligation of the group leader to report to the supervising officer any serious violations of law or probation or parole conditions and regulations.

A change in technique was effected with the second group from the "hard sell" to the "soft sell." The use of the terms "alcoholic" and "alcoholism" was minimized; "problem drinking" and "uncontrolled drinking" were substituted. The stigma of alcoholism persists, and affects those in every stratum of society.

Amazingly, the group participants at the outset often readily identify with "problem drinking" but not with "alcoholic drinking." But, as time passes they start relating to the identification of "alcoholic," and realize the burdens their problem places on their families and the difficulties it creates with their employers and with society.

On occasion "role playing" has been utilized effectively. It is planned to use this technique to a greater degree. Occasionally "chalk talks" (illustrated chalk board talks) are used, and have been found to be effective.

Group dynamics are observed carefully. A summary report of each meeting is later recorded at length for subsequent review and evaluation. The meetings, scheduled for one hour, usually run 1½ to 2 hours. This is considered significant.

Group counseling, rather than individual counseling, has proved to be more effective in meeting the needs of alcoholics. However, individual counseling frequently takes place after the meetings are concluded and is available when needed or requested by the officer supervising the case.

Group counseling is a practical and economical method of treating a large number of persons. In a group setting the sensitive person is afforded the opportunity of being with others with a like problem and can recognize that he is not unique and alone. He hears others discussing their problems and can better understand his own. The barrier of isolation is broken down. He sees and speaks with and to others with the same experience and problems. He eventually gets a better understanding of himself, his problem and what can be done about it. He learns that alcoholism is a complex disease.

The Alcoholic Counseling Group attempts reeducation through group counseling. The effort of the program is directed toward self-appraisal, insight into individual problems, responsibility of self-analysis, and self-directed goals in life. The group attempts to build a supportive and therapeutic relationship and at-

(Continued on page 24)

Hints on Helping the Alcoholic Probationer or Parolee

BY EDWARD A. KENEALY

FIELD REPRESENTATIVE
ALCOHOLISM SECTION
WASHINGTON STATE DEPARTMENT
OF HEALTH

If a treatment program is to be successful, the officer must set realistic goals and provide the type of motivation that will persuade the probationer to accept treatment.

Reprinted by permission from *Focus*.

THE duties of a probation officer are numerous, but essentially as a court officer, he is responsible for the protection of the community from the convicted offender granted probation and for the rehabilitation of the offender admitted to probation. Excessive caseloads and court investigations often make it impossible for a probation officer to become involved in long periods of correctional counseling. Therefore, he should become involved in the community team approach if the alcoholic probationer is to receive adequate treatment. If the probationer is able to recover, there is an excellent chance of satisfactory completion of probation.

The probation officer will not be able to develop an effective treatment plan for the alcoholic probationer until he understands alcoholism. To treat alcoholism successfully, you must understand why it is an illness and the types of treatment available to the alcoholic. This information can be obtained through personal contact with official and voluntary alcoholism treatment agencies, state and local health agencies, combined with reading.

Prior to attempting to supervise an alcoholic probationer, the probation officer should attempt to understand his own feelings about drinking, drunkenness, and alcoholism. He must recognize his personal limitations and acquire the ability to accept the alcoholic "as he is."

The alcoholic is often a sensitive person, who can detect rejection and lack of understanding in the officer. The officer must develop the courage to confront the alcoholic with the reality of his alcoholism. Communication must bring forth an empathic understanding between the officer and the probationer.

The probation officer's first responsibility is to enforce the probation order as issued by the court.

It can be argued that a probation order stating that the probationer shall not use intoxicating liquors or frequent places where liquor is sold is unrealistic. It is difficult for the officer to enforce this order, as in the majority of cases the alcoholic will have a relapse during recovery.

If the proper communication exists, this dilemma is resolved on the merit of each individual case. The important factor is that the alcoholic can benefit by treatment; and individuals eligible for probation should not be denied the opportunity for probation because they are alcoholic or problem drinkers.

Deciding who should be granted probaion is the decision that is being made each day by the courts upon recommendation of the probation officer.

Evaluation of an alcoholic case can be extremely difficult, as the officer is constantly aware of the fact that the rate of recidivism is high.

The officer must determine how al-

cohol affects the defendant's behavior: Does he only commit crimes when intoxicated? If so, why? What risks are involved in granting probation to an alcoholic defendant? Will a return to future criminal activity become a serious threat to the community? Is the defendant motivated to accept treatment for alcoholism? What type of treatment can the probationer obtain within his community?

These are the kinds of questions the probation officer must answer prior to submitting a recommendation to the court regarding the defendant's eligibility for probation.

In answering these questions the officer will be able to develop a treatment plan for the defendant, if he is granted probation.

What decision must be made if the alcoholic is not eligible for probation? The court will either sentence him to county jail or to prison, if incarceration is recommended.

The defendant will always view this type of action as punishment—a loss of freedom. Because of his extreme bitterness, it is unlikely he will be motivated for treatment—unless the probation officer is willing to work through this problem prior to the defendant's commitment.

The court or officer should not oversell the treatment programs existing within the penal institutions, as these institutions are not designed for the treatment of alcoholism.

Alcoholics Anonymous groups exist within the majority of the institutions; but, unfortunately, many inmates attending are not sincere. Many inmates attend the A.A. meetings only to create a favorable impression upon the parole officials or as a diversion from prison life.

"That probation officer of mine is a real card. He says alcoholism is an illness—but he'll revoke my parole if I get sick."

The prison social workers are overburdened with excessive paper work. Therefore, little time is given to counseling. The penal institution that brags about its psychiatric services is usually misleading the public. Psychiatric treatment is almost nonexistent in the majority of the penal institutions. Usually, psychiatric evaluation is all that exists.

Often the alcoholic inmate is not given an opportunity to enter into a vocational training program, as it is felt he cannot succeed on parole. Classification committees' actions indicate that vocational training programs should be limited to inmates who are good parole risks. Many an inmate is considered a poor risk for parole only because he has not been afforded treatment.

The courts and probation officers do not want to be led into a trap of committing an alcoholic defendant to a penal institution for the sole purpose of treating the defendant's alcoholism. The defendant can better be treated for alcoholism in a hospital, alcoholism treatment clinic, halfway house, probation officer's office, or through A.A.

Correctional treatment begins with the first interview between the probation officer and the convicted offender. The officer must be aware of the common personality characteristics of alcoholics, if he is to evaluate properly the defendant who, he assumes, may be alcoholic.

The alcoholic almost always has difficulty in recognizing his drinking or alcoholism as being a problem.

He will continually deny that a problem exists, evading the issue to avoid discussing his drinking habits.

He cannot admit he has lost his ability to choose when, where, and how much alcohol he will consume.

If he does admit to excessive drinking or loss of control, he may blame his wife, boss, or someone else as the cause of his drinking.

Some alcoholics are impulsive individuals, which is associated with emotional instability. An alcoholic may suddenly decide to quit drinking, as quickly as he decides to have his next drink, without thinking out the situtation. During his illness, however, the alcoholic often appears to be quite positive in making decisions regarding his future.

The alcoholic often displays guilt feelings, openly admitting that he does not deserve the probation officer's help with his personal problems. He sees himself as socially unacceptable to society.

The probation officer should be cautious when the alcoholic displays overconfidence in his ability to stop drinking. Ninety-nine out of one hundred fail to do so. This type of alcoholic stops drinking only at death. Ideally, compulsory treatment should be initiated.

The alcoholic has often been described as a dependent person; he has developed ingenious techniques to create this dependency. He manages to develop a relationship with individuals willing to provide for his emotional and economic needs.

The male alcoholic has difficulty in accepting the sexual role of a mature man, husband, and father. This gives his wife an opportunity to "wear the pants", thus creating new problems in the home for the alcoholic. This type of alcoholic requires intensive counseling, often past the period of probation.

The probation officer must realize that the alcoholic is often hostile toward authority. He resents interference with his drinking, believing his problem is exaggerated. He resists treatment; and it is not uncommon for the alcoholic to manipulate the officer into developing an unrealistic treatment program that will fail. This type of maneuver will give the alcoholic an excuse to return to drinking and use the probation officer as the scapegoat.

The probation officer's counseling must be reality oriented; the facts must not be twisted to benefit the alcoholic. The alcoholic must stop drinking; to re-

"I'd like to leave a message for the parole officer."

cover from this illness, he must accept treatment.

Dr. E. M. Jellinek's study on the progressive symptoms in alcoholism indicates that the majority of alcoholics go through four phases during this illness. The probation officer will be able to detect telltale signs of alcoholism if he has studied Jellinek's chart, "Phases of Alcohol Addiction in Males."

Clinical experience indicates that during any one of these phases, drinking can be controlled by the individual if he is motivated to seek treatment. The alcoholic can be forced into treatment during the early phases of alcoholism. He must be motivated for treatment prior to a referral to a treatment agency. In cases, the fact that the alcoholic has been arrested, convicted, and admitted to probation is a motivating factor.

The alcoholic develops a rationalization defense mechanism which grows with the illness. The alcoholic uses this defense mechanism to maintain his self-esteem and continue drinking without suffering overbearing guilt feelings. Without the collapse of this alibi structure the alcoholic will not accept treatment.

The alcoholic will not accept treatment until he is able to comprehend the seriousness of his illness. He must accept the facts regarding his illness: that he suffers from a chronic but treatable illness. He cannot recover if he continues to drink; this is an important factor in recovery, but is not to be considered the only requirement. He must be willing to accept treatment if he is to develop the necessary self-understanding to accept life for what it really is.

The team approach in the motivation of the alcoholic has a greater chance of

(continued on page 22)

Investigating

NEW CO
HOSPITAL

Lapidary is one of the recreation skills being taught at the ARC.

THE North Carolina Alcoholic Rehabilitation Center is currently in the process of carrying out a project designed to investigate a broadened concept of hospital recreation. The project, known as "New Concepts in Hospital Recreation," is a Hospital Improvement Project (H.I.P.) supported by a grant from the United States Public Health Service in cooperation with the ARC. This project has the possibility of directly affecting the concept of hospital recreation as we know it today and becoming an historical turning point in recreation.

The formal organization of recreation programs in the hospital setting is relatively new. Certain services have been carried on through the centuries, but the development of current concepts of hospital recreation really began during World War II. When hospital recreation was initiated in the military hospitals during the war, the emphasis was then, as it is now, directed toward helping effect a shorter stay in the hospital. Constructive use of leisure could make the patient more receptive to treatment and hence facilitate his recovery.

Following World War II, hospitals concerned with treating the mentally ill began to establish recreation departments. These departments were staffed to a large degree by personnel trained in the military hospitals or within the special services division of the Armed Forces. Thus the concepts of hospital recreation which were developed for use during the war were transmitted to the mental hospital setting. Recreation as a new therapeutic instrument flourished for this was before the extensive use of tranquilizers in the treatment of mental illness and at a time when patients were admitted on a long-term basis.

NCEPTS IN RECREATION

BY SIDNEY R. OAKLEY

DIRECTOR OF RECREATION
ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

We must determine how recreation can contribute to the total rehabilitation of the alcoholic—while he is in the hospital and when he returns later to his home community.

Dr. Charles Brightbill in his book, *Man and Leisure,* lends support to the current concept that "the role of hospital recreation is to effect an early recovery" in his definition of hospital recreation: "Recreation therapy is the medical application of an activity voluntarily engaged in by the patient *during the period of treatment or convalescence.*"

This concept is also supported by Dr. Norman P. Miller and Dr. Duane M. Robinson in their book, *The Leisure Age*: "The basic purpose (of hospital recreation) is to help the patient to maintain a frame of mind, attitude and morale that will make him most receptive to and cooperative with the medical treatment and eager to work to get well or to tolerate his disabiilty or handicap more easily and enjoy life more fully despite it."

The pre-project recreation program of the ARC was operated under the traditional or diversionary concepts of hospital recreation. However, because of its past experience, the ARC feels that the diversionary uses of hospital recreation—bus rides, bingo games, etc.—are inadequate and that they have not kept pace with the current philosophy of rehabilitation.

Throughout the fifteen years of its existence, the ARC has modified its treatment program in the light of new knowledge to provide maximal benefit to the alcoholic patient. During the last five of these fifteen years, a recreation program has been part of its total rehabilitation program.

The recreation program was started on a modest scale with only one professional recreator employed on a half-time basis; however, after a few months it was obvious that the recreation needs of the patients were not being met and a full-time recreation position was established. The following year a position was opened for a student to work in the program during the summer months, and in 1965 a rehabilitation aide was added to the recreation staff.

Although the recreation program has grown in terms of budget and personnel since its inception, its greatest growth has been the realization that the current concepts of hospital recreation under which it operates are inadequate and must be broadened if they are to meet the needs of the alcoholic patient, whether he is in a mental hospital or specialized treatment center.

The past experience of the ARC has shown that there is a definite need for the patient and his or her spouse to receive competent counseling on the subject of utilizing leisure time positively after the patient is discharged, information on what recreation resources are available in his home community, and instruction in

recreation skills.

The initial ARC recreation program included the usual recreation activities: bingo games, horseshoe tournaments, movies, pencil games, and other such activities. From the beginning, it was a success in terms of improving patient morale; however, it was also evident that the program did little to prepare the patient to use his leisure time in a satisfying and rewarding manner when he returned home.

Consequently, in 1963, a group therapy session on the use of leisure time was incorporated into the structured part of the ARC's treatment program. The film, *Of Work, Time and Leisure,* was used as a stimulus to group discussion.

Research Project

As a result of the discussions in these group therapy sessions, a research project to determine the leisure patterns of the patients admitted to the ARC was undertaken. The first 150 patients admitted in 1965 were subsequently interviewed to determine what leisure interests and skills they possessed. Interestingly, the inner resources of the individual were found to be the important factor in the choice of leisure pursuits. Age, education and income were influential but not as important as might be expected.

The results of this study confirmed the findings of an earlier study by Dr. Norbert Kelly on the leisure patterns of 217 North Carolina problem drinkers. He found that less than one-fourth pursued any form of recreation which required active (self-involved) participation. Their interests were of the passive, uncreative spectator type. Creative avocations were absent almost to the point of nonexistence.

As mentioned earlier, the traditional or diversionary concepts of the use of recreation do not meet the recreation needs of alcoholic patients. Such an approach is narrow and restrictive in that its chief goal is to provide diversionary experiences for the patient during the time that he is actually in the hospital. If we are to treat the *whole* patient, then it is imperative that we examine our approach to the use of recreation to determine in what ways recreation can contribute to the total rehabilitation of the alcoholic not only while he is in the hospital, but also when he returns to his home community.

Because of the lack of personnel, the ARC was not able to incorporate leisure counseling into its preproject program. The aims, however, under the project are to develop new concepts of hospital recreation which will utilize a leisure counseling service and adapt the curriculum concept of teaching leisure skills in the hospital setting.

The need for such a service was pointed out in 1962 by Dr. R. J. Blackley in an article which appeared in the *North Carolina Recreation Review:* "In the practice of psychiatry, I find so many patients say that their interests are very limited. Spouses often have little in common, rarely get out of home together. Many times getting these people to understand the importance of recreation is a great step to helping patients get well."

It was previously brought out that the inner resources of the patient appear to be the most important factor in the lesiure choices that the patient makes. A hypothesis to be tested in the project is: If a system is established at the ARC whereby the patient receives competent, progressive instruction in several leisure skills, then the chances that the patient will continue to pursue these

A course in art is offered.

leisure skills when he returns home will be greatly increased.

In contrast, the pre-project recreation program operated under the hypothesis that the patient came to the center equipped to use his leisure positively; but from observations and research at the ARC, this hypothesis has been proved false.

The role of recreation in the hospital setting can be more than providing necessary equipment and supplies and keeping the patient happy. Indeed, it must, if it is to fulfill its potential, provide leisure counseling and competent instruction in leisure skills.

The concept of leisure counseling and the curriculum concept of teaching leisure skills is new to the hospital setting. Previously, patients have played softball and bowled, but the emphasis has been on participation and enjoyment of the activity rather than the goal of learning or improving one's skill in the activity. Ironically, one's degree of continuance and the degree of enjoyment of an activity is directly related to the skill that one possesses in a given activity. Few people continue to pursue a given activity unless some degree of skill has been learned.

Many factors and changes—in hospitals, treatment, the times—make it imperative that the current concepts of hospital recreation be reexamined. When the current concepts were formulated over twenty years ago, the patients' stay in the hospital was much longer than it is now. The trend now is to admit patients on a short-time basis. In 1964, for instance, the median length of stay in the state's four mental hospitals was 32 days. Concurrently with the decreased hospital stay has occurred a rise in the the use of halfway houses in the total rehabilitation of the mental patient and the alcoholic. These two factors necessitate a broadened use of hospital recreation or a change in emphasis from diversion and morale building to preparing the patient to use his leisure time wisely when he returns to the halfway house or his home community.

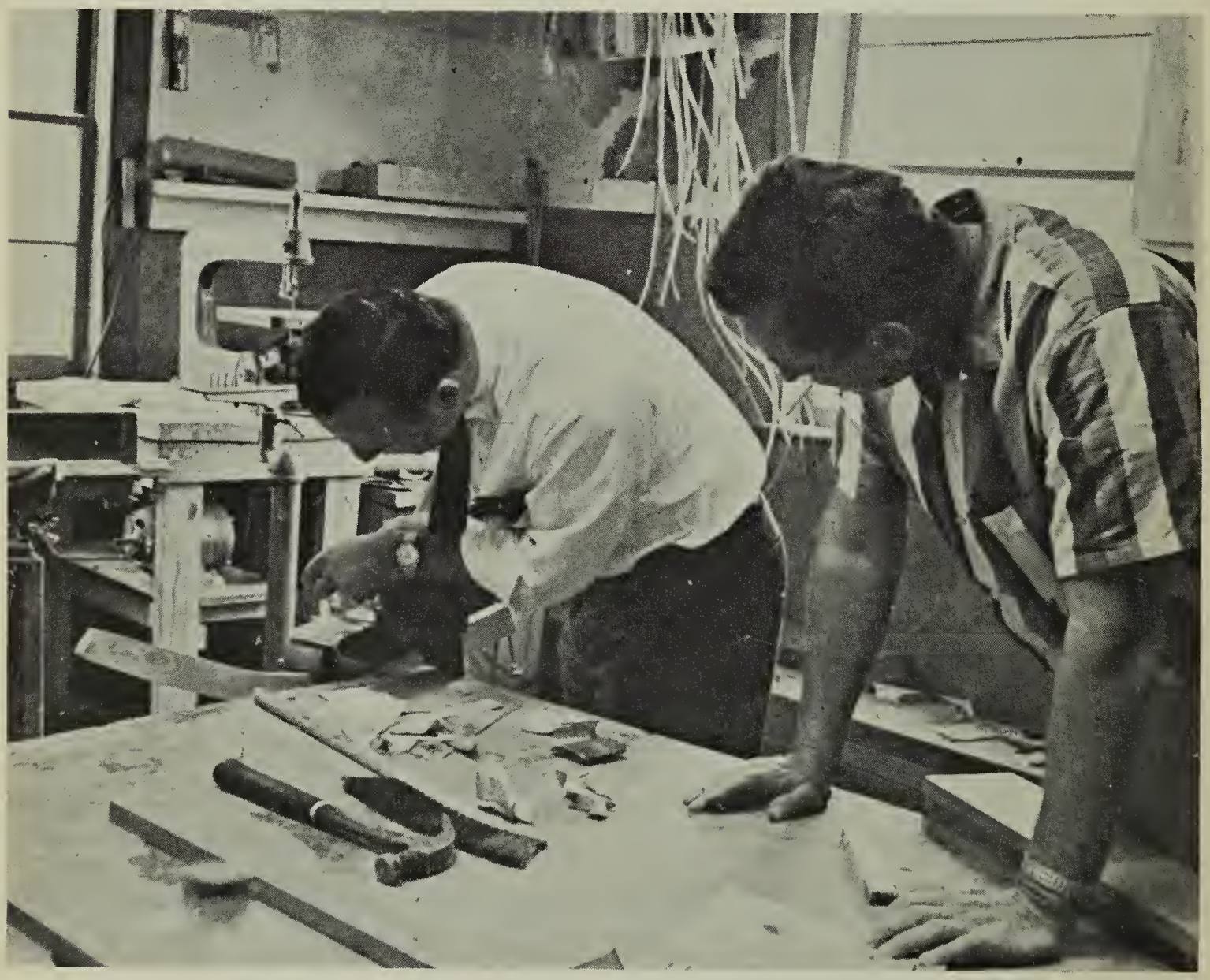
Another significant factor is that the municipal recreation departments have begun to employ qualified recreation personnel to work with patients returning to their community from the state hospitals and the rehabilitation centers. The reexamination is needed to find ways of strengthening communication between the treatment centers and the municipal recreation departments.

The changing role of work and leisure in our society also requires us to reevaluate our current concepts of recreation in general and hospital recreation in particular. With the gradual reduction of the work week, increased holidays, vacations and mandatory retirement, forced leisure has become a problem to many people.

Forced leisure brings a great emptiness to the alcoholic. Perhaps Robert MacIver, in his book, *The Pursuit of Happiness,* had in mind the alcoholic when he wrote: ". . . leisure becomes a void, and from the ensuing restlessness men take refuge in delusive excitations or fictitious visions, returning to their own earth no more."

Dr. Alexander Reed Martin has been concerned for some time with the psychiatric problems related to the misuse of leisure time. Although not writing specifically about alcoholics, he could have been for he has adequately described, in "Leisure Time as a Health Resource" from *The Leisure Age,* the dilemma that the alcoholic faces regarding the use of his leisure time: "Caught off-guard, unprepared, uneducated, unequipped emotionally and psychologically to make creative use of leisure, there is a consequent misuse of it. Instead of leisure time fulfilling its natural, biological function of enriching life and promoting creativity, instead of serving as the parent of philosophy and the arts, a very high proportion of leisure time activities are drafted into the service of various and often conflicting compulsive needs. For example, the need to conform, to compete socially, the need to escape, the need for togetherness, the need to prove superiority and uniqueness . . . (Make us) now the victims of inner compulsions that make the wise use of leisure impossible."

The findings of the reexamination and testing of new concepts in hospital recreation being undertaken in the project will have a much



Woodworking may provide many enjoyable leisure hours for some.

wider application than their value in treating the patients of the ARC. The type and use of hospital recreation developed will, to a large extent, influence the type and use of hospital recreation in two additional alcoholic rehabilitation centers to be built by the State of North Carolina in the near future.

Should the proposed concepts of hospital recreation prove to be more beneficial in helping to rehabilitate the alcoholic patient than the current concepts, then there is reason to assume that they could also be applied to hospitals which treat the mental patient as well as the alcoholic. Today, in the mental hospitals of the State, the alcoholic comprises a large segment of the patient population. In one state mental hospital in 1964 one out of every four patients admitted was admitted for alcoholism. The same picture generally holds true for the other three hospitals.

The project, which will be integrated into the ARC's total rehabilitation program, will require the cooperation of all regular staff members, the full-time participation of two, and the part-time assistance of fourteen others, as well as four new full-time staff members and seven part-time workers. In addition, there will be additional recreation students and hospital volunteers working in the program.

In 1964 the median age of patients admitted to the ARC was 39; the age range was from 18 to 67. During the three-year period of the project, it is anticipated that 2,000 patients will have been served. Both male and female patients will be included with an expected ratio, based on past experience, of six males to one female. It is reasonable to assume that the median age will continue to be about 37.

The evaluation plans for the project include a personal follow up on the first 150 patients who are admitted to the ARC for treatment after December 31, 1966. The follow up will be restricted to patients who reside within a 100 mile radius of Butner, N. C. where the ARC is located. Such a sample will be adequate, however, because it will include a large Eastern rural segment of the population and also include patients from larger cities such as Durham, Greensboro and Raleigh. In addition to the information that will be gathered on the patient's use of leisure time since discharge, other data such as sobriety, vocational problems, use of other counseling services, such as family service, mental health clinics, welfare department, minister, physician or alcohol information center, will be explored with the patient.

Gravest Crisis

What the import of this project will be remains to be seen, but Robert Lee in *Religion and Leisure in America* has this to say about the importance of the subject under investigation: "On an end-of-the year roundup television program, a number of distinguished news commentators were asked, 'What is the gravest crisis facing the American people in the year ahead?' Many answers were given. One person suggested heightened cold-war tensions, another thought Latin America, another said the independent nations of Africa, and a fourth felt Berlin would provoke the gravest crisis. Around the table the discussion went, until it came Eric Sevareid's turn to comment. In striking contrast to the others, Sevareid stated that he thought the most dangerous threat to American Society is the rise of leisure and the fact that those who have the most leisure are the least equipped to make use of it."

ALCOHOLIC PROBATIONER

CONTINUED FROM PAGE 15

succeeding than the individual approach; therefore, it is advisable that the probation officer enlist assistance from the probationer's family, physician, clergyman, and employer. All persons must agree upon the plan of action prior to the confrontation.

The alcoholic must be confronted with the facts regarding alcoholism, diagnosis fitted to his behavior, plan for recovery, and prognosis if he refuses treatment. He must be made aware of the fact that he is on probation because of criminal behavior, caused by his inability to control his action while drinking, and if he does not seek immediate treatment his chances of succeeding on probation are very poor. He should be made to understand that a probation violation will probably bring forth a jail or prison sentence, a loss of freedom.

If he believes you are threatening or bluffing, he will not accept these facts. The alcoholic will need your confidence in his ability to recover and not your sympathy.

The community team approach is most important in the treatment of an alcoholic in the probation setting. The probation officer is neither qualified nor does he have the time to provide adequate treatment for the alcoholic. Most alcoholics require medical care, supportive counseling, and alcohol education prior to recovery. Other alcoholics may need psychiatric treatment, welfare assistance, vocational rehabilitation, assistance with employment, residence in a halfway house, and religious counseling.

The alcoholic must be required to meet his financial, legal, and marital obligations, as this is an important phase of recovery, as well as correctional rehabilitation.

The probation officer must be aware of alcoholism treatment facilities which exist in the community. He should know what type of treatment is offered by each facility and its cost.

The information and referral center is the proper agency to which to refer the alcoholic probationer for evaluation. He will be evaluated and referred to an official or voluntary alcoholism treatment program, such as an alcoholism hospital, a clinic, or Alcoholics Anonymous, if needed.

If an information and referral center does not exist, nor clinics, the probation officer must be prepared to assist in the development of the diagnosis with the assistance of the community team.

The team must decide what type of treatment is required for recovery.

The probationer must understand the purpose of referral and the need for continuing with treatment. When the alcoholic has been placed in a treatment program, the probation officer should periodically contact the agency providing treatment to determine his progress. Contact with the probationer's family is essential, as their support is needed.

Success will not be forthcoming if the alcoholic's social environment has not changed. Positive changes within his family must occur. This is difficult for the family as they have learned not to trust him with responsibility, forcing the wife into assuming the dual role. The children lack confidence in their father, as he has disappointed them in the past.

The probation officer should encourage the family to participate in the treatment program by attending Al-Anon and Alateen to obtain a better understanding of this illness.

If treatment fails, all parties involved should be contacted in order that a fair evaluation can be made upon the probationer.

In summation, if a treatment program is to be successful, the officer must set realistic goals which are effective. The officer must provide the type of motivation needed by the alcoholic probationer to seek and accept treatment.

The officer needs self motivation to accept this challenge which is often frustrating, if he is to succeed with the alcoholic probationer. After working closely with A.A., alcoholism treatment hospitals, clinics, and diagnostic centers, the officer will be encouraged by witnessing success.

The officer must not accept the alcoholic's failures. That is the obligation of the alcoholic. Without it his chances of recovery are poor.

If the proper alcoholism treatment facilities do not exist within your community, the probation officer is professionally obligated to assist the community's voluntary groups in their endeavor to obtain these treatment facilities.

To assist the probation officer in his supervision of the problem drinker or alcoholic probationer, I am offering the following "Do's and Don'ts" in the supervision of the alcoholic probationer.

DO develop an attitude to parallel the facts.

DO assess your own feelings, i.e., are your emotional biases blinding you to the facts of the probationers' behavior?

DO recognize the constellation of symptoms from which diagnosis of alcoholism can be made.

DO know the process of alcoholism recovery. What type of program does each resource offer and to what type of individual? Learn how to refer probationers professionally.

DO understand that relapse occurs, as in any other illness. This may be the most important phase of recovery. Learn the symptoms; you will be able to predict a relapse.

DO keep the responsibility where it belongs. The drinking problem belongs to the probationer, not you.

DO be consistent in supervision of the alcoholic probationer. He lacks emotional maturity and often is a product of inconsistent treatment.

DO discuss alcoholism problems with the probationer regardless of his desire. It can be assumed that the majority of cases will be reluctant to discuss this problem, but if recovery is to be obtained the individual must admit he has an alcoholism problem and accept treatment.

DO counsel with the alcoholic probationer's family regarding his illness. Learn how his illness developed and if treatment has been effective.

DO be reassuring, commend the alcoholic for progress and encourage him to continue with prescribed treatment programs.

DO contact agencies, clergymen, and employers if they are aware of his legal status, to discuss the probationer's alcoholism and effectiveness of treatment programs.

DO understand the Alcoholics Anonymous program. No one can acquire an understandnig of A.A. without reading the book, Alcoholics Anonymous, **and attending five meetings with different groups. It is helpful to become acquainted with six or more recovered alcoholics from all levels of the community.**

DO assist with the promotion of a community alcoholism council, information and referral center, and alcoholism clinical services for the treatment of alcoholism.

DO assist in the development of halfway houses for alcoholics in your area. Regular visits to these houses will be beneficial to your supervision of alcoholic probationers.

DON'T continually threaten the alcoholic probationer with revocation if he fails to follow your instructions regarding treatment. If he is in violation, violate him immediately; he knows he is in violation and expects you to initiate the proper action. This type of learning experience can be beneficial.

DON'T preach or lecture to the alcoholic probationer, using a "holier than thou" attitude—approach him with realistic counseling involving the pertinent facts of his case.

DON'T fully accept the alcoholic pro-

bationer's version of existing family, employment, and drinking problems. Check with other persons involved and confront the probationer with the truth.

DON'T accept the alcoholic probationer's excuses regarding his drinking. His entire future depends on complete abstinence.

DON'T treat the alcoholic probationer as a child, even though he appears to be emotionally immature. Insist that he accept responsibility for his personal problems and maintain employment, after he is physically capable.

DON'T give unintelligent advice. Let the psychiatrist treat the mentally ill, the physician treat the physically ill, the clergymen counsel those needing religious help. Understand alcoholism and use the teamwork approach.

DON'T become discouraged with the slow treatment process, the probationer may need continued treatment after his probation has terminated. Re-socialization is often a long, slow, painful process for the alcoholic.

DON'T agree with the alcoholic probationer who attempts to assure you that he can return to moderate social drinking after probation is terminated. Total abstinence is a must for the alcoholic. Long term controlled drinking is not possible for an alcoholic.

DON'T refuse counseling to an alcoholic probationer who has contacted you for immediate assistance with an urgent problem. No schedule is that tight.

DON'T become discouraged if counseling has been ineffective, as the alcoholic has difficulty establishing satisfactory personal relationships. He has had difficulty cooperating and often feels that people have failed or rejected him. He places excessive expectations upon those who are to assist him with his illness.

DON'T deny a defendant the right to probation simply because he is an alcoholic. Would you deny a patient with cancer or tuberculosis treatment? Cancer, TB, and alcoholism can be treated.

CONSTRUCTIVE COERCION

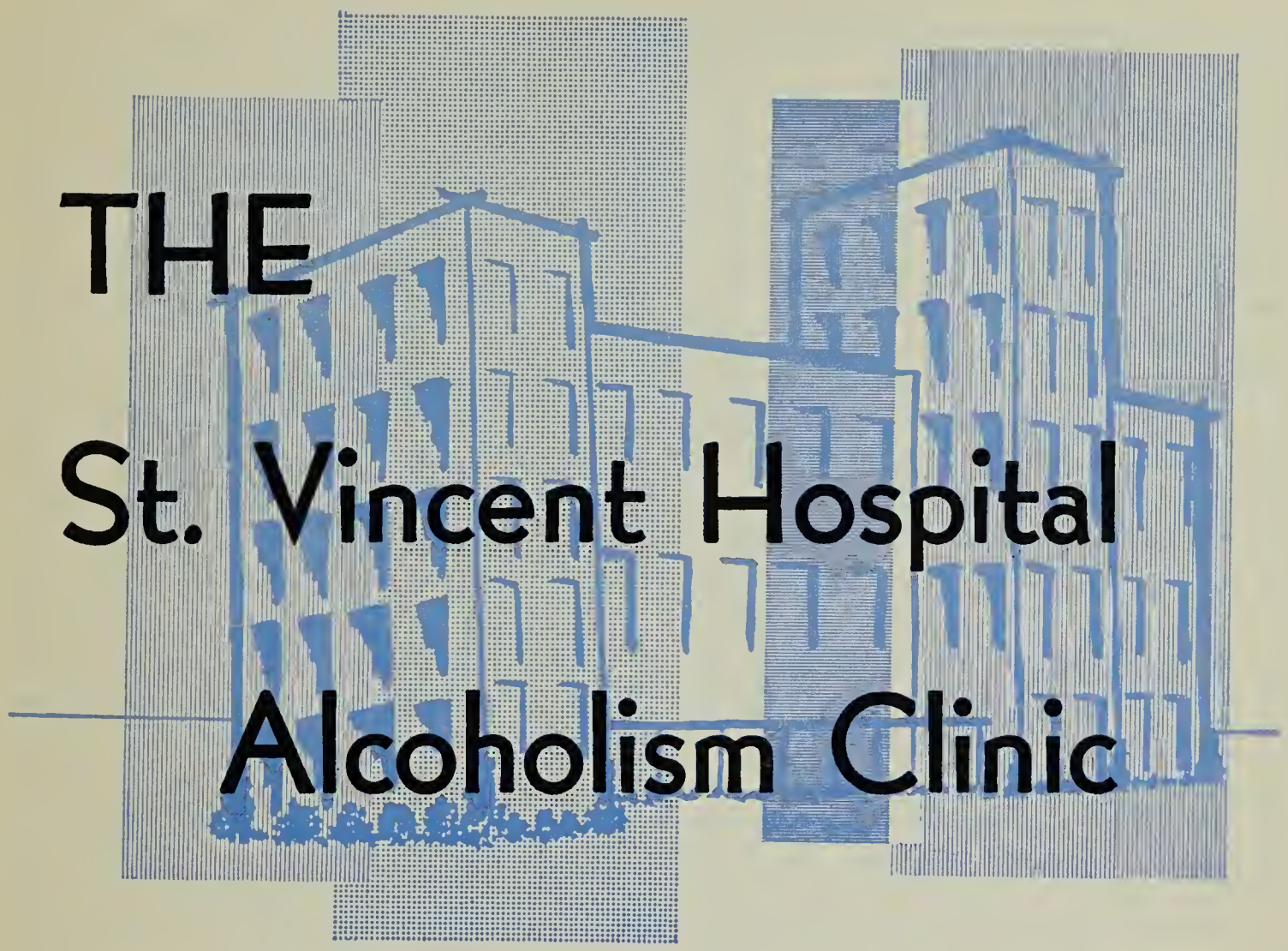
CONTINUED FROM PAGE 11

tempts to direct the individual's thinking into channels of honest self-appraisal and control. An effort is made to help him to develop new patterns of thinking, social behavior, and self-gratification. In effect, the sessions often become lessons in good citizenship. Emphasis is placed on the availability of help through the program of Alcoholics Anonymous simply because as far as can be ascertained, no other local or state alcoholic rehabilitation program, whether it be conducted in a hospital, clinic, court or elsewhere, has demonstrated that its program and efforts have reduced alcoholism or even stemmed its increasing rise.

The availability of the help through A.A. is unmatched by most programs. Its services are free to the individual and the community and are available 24 hours a day, 7 days a week, and 52 weeks a year.

There is no definite yardstick by which success can be measured. This is especially so when one considers that the alcoholic has the problem for the remainder of his life. In some instances, at the end of the group of sessions, there is tangible evidence of comprehension. In other instances the seeds of understanding hopefully planted may eventually bear fruit. If nothing else, exposure has given some of them an understanding that they never had before.

It is important that the individual be given a chance to become aware of his problem and given the opportunity to be helped in doing something about it. As probation and parole officers, we must use our authority constructively and intelligently in order to carry out our obligations to our profession and to those whom we are trying to help.



THE St. Vincent Hospital Alcoholism Clinic

The general hospital which accepts alcoholics improves its public relations and fulfills its total purpose — care of the sick.

THE St. Vincent Hospital Alcoholism Clinic was inaugurated in June, 1954. It is one of sixteen such clinics subsidized by the Division of Alcoholism of the Massachusetts Department of Public Health. The clinic is staffed by two staff physicians, an internist and a psychiatrist; one full-time social worker; six part-time social workers; a part-time clinical psychologist; a medical resident; a receptionist and two stenographers. The physicians are also engaged in private practice in the community and consequently their association with the alcoholism clinic should be considered as a part-time duty.

BY JAMES M. MORRISON, M.D.

St. Vincent Hospital in Worcester, Massachusetts is a 659-bed, privately endowed, general hospital administered by the Sisters of Providence. It is a teaching hospital and employs a full-time Director of Medical Education with full accreditation for the training of interns and residents. The hospital has a fifty-one bed open

Permission to publish this article in *Inventory* was given by the author. Dr. James M. Morrison is the Physician-in-Charge of the St. Vincent Hospital Alcoholism Clinic at Worcester, Mass.

psychiatric unit, and the alcoholism clinic offers both inpatient and outpatient care depending upon the needs of the individual patient.

For a clear understanding of the overall inpatient care of the chronic alcoholic patient at St. Vincent Hospital, I would like to explain the rather unique accommodations which at present are being utilized. A specialized unit for the male chronic alcoholic comprising four beds is provided on the general medical floor. Female patients are admitted to the general medical floor as "special" cases. Patients under the care of the clinic psychiatrist may be treated on the hospital psychiatric unit.

The St. Vincent Hospital Corporation in 1953 was contacted by the Worcester County Council on Alcoholism, Inc., a lay organization made up of community leaders, to establish an Alcoholism Clinic under the sponsorship of the Massachusetts Department of Public Health. Through the encouragement and approval of the president of the hospital corporation, Bishop John J. Wright of the Diocese of Worcester, and the administrator of the hospital, Mother Mary Loreto, S.P., the Alcoholism Clinic was accepted and approved by the hospital corporation and the medical staff of the institution.

No specific medical staff by-laws are written for the admission and treatment of alcoholics but the following articles, recently revised, cover the aims of the hospital staff in its contact with all patients:

Article I. Section 2—Purpose

"The purpose of the organization shall be:

1. To insure that all patients who come to the hospital will receive the best possible care.

2. To provide medical education and maintain medical educational standards.

3. To maintain and support an active department of medical research."

The alcoholic readily adjus

An orientation lecture on the treatment of the chronic alcoholic in the general hospital is given to each house officer during the first month of his training at St. Vincent Hospital. Since the hospital has a large emergency room service, the house officer is cautioned to evaluate the intoxicated individual who presents himself to the emergency room for treatment on an individual basis in deciding whether hospitalization is warranted. The inpatient and long-term follow up outpatient treatment of the chronic alcoholic is outlined in the orientation lecture and the disease concept of alcoholism is stressed. Routine admission orders, including medication and laboratory procedures, are posted in the nursing station files for use by the nursing personnel.

Rules concerning visitors are the same for the alcoholic patient as they are for the patients with other illnesses. The alcoholic patient is encouraged to have visitors who may be utilized in the overall therapeutic program, namely: twelth step Alcoholics Anonymous representatives, the employer, and the clergyman as well as the family. A formal schedule of visits to the four-bed medical ward by an A.A. representative has been followed for several years.

Student nurses are taught to render to the alcoholic the same degree of kindness, sympathy, and diligent care given to patients with other illnesses. Since our male ward is located on a general medical floor, the

nursing care provided for the alcoholic is the same as that given to the other medical patients.

It has been our experience that the atmosphere of acceptance of the alcoholic as a sick patient worthy of treatment, an attitude reflected in the nurses' contact with the patient, is important to the sick alcoholic who is depressed and filled with guilt and remorse yet apprehensive that he will experience the same type of rejection that he has experienced outside the hospital. It has been our experience that such patients adjust very readily to a routine and treatment program which is based on sympathy and patience. Occasionally an emotionally disturbed individual will refuse to conform to our hospital routine and he will be allowed to leave the hospital or will sign out against advice. This is by no means a common occurrence.

Since the chronic alcoholic patient may have a variety of medical complications such as Laennec's cirrhosis, jaundice, ascites, peripheral neuritis, gastritis, pneumonia, etc., all the facilities of the general hospital may be utilized at times in caring for these patients. It is important to stress that the whole patient, physical and emotional, should be treated, not merely the withdrawal of alcohol from his system.

Our routine admission orders filed in the nursing station procedure book include the following orders for alcoholism: "1000 c.c. 10% Fructose in distilled water with 10 units of regular insulin and 1 ampule of B-complex intravenously; Chlordiazepoxide, 50 mgm. initially, followed by 20 mgm. q.i.d.; CBC, Urine, Fasting Blood Sugar, BUN; Chloral Hydrate, gr. 15 at bedtime; Chest X-ray and Electrocardiagraph; Full house diet, liberal fruit juice."

Such orders are subject to variation depending upon the individual needs of the patient. Many of the so-called tranquilizers are of great value in combatting the terrible withdrawal symptoms of alcoholism. Such medications as chlorpromizine, chlordiazepoxide, promazine, meprobamate, sodium dilantin, chloral hydrate, ACTH, disulfurim and citrated calcium carbomid are among some of the more common drugs used in the treatment of chronic alcoholism. Multivitamins and vitamin B-complex preparations together with intravenous glucose or fructose are other medications used in the treatment routine at St. Vincent Hospital.

The alcoholic patient receives the nursing care provided by the general medical floor. Patients on the psychiatric unit are cared for by the nurses assigned to that unit. Although our overall system of nursing care for the chronic alcoholic is adequate, we feel that many improvements could be made in several areas of our therapeutic program.

There is still a reluctance on the part of many physicians and nurses to fully accept the alcoholic as being afflicted with a true disease who merits a bed on the same priority basis as patients with other illnesses. In our institution this concept is further strengtened by the fact that we have an acute bed shortage with a waiting list for admission and patients are admitted from this list on a priority basis depending upon the nature of the illness. I dare say that practically all of the general hos-

(continued on page 30)

A feature designed to help you keep posted on developments in the field of alcoholism.

GREENVILLE, N. C.: The Pitt County Alcohol Information & Service Center, the Wilson County Council on Alcoholism, and the Craven County Council on Alcoholism were hosts to the Spring Meeting of the Alcoholism Programs of North Carolina April 19 and 20 at the Greenville Moose Lodge, Greenville. On hand to inform the group about pertinent events in legislation and its progress were Senator Sam Whitehurst and the Honorable Walter Jones, U. S. Congressman. "Would-be" speakers included Pat Taylor, chairman of the N.C. Board of Mental Health, and Jay Cross, director of the Alcoholism Project of the American Public Health Association. Both were unable to be present, but their remarks and messages were presented in their behalf by Worth Williams, executive director of the Greensboro Council on Alcoholism, and Marshall Abee, president of the APNC, respectively. Dr. M. M. Vitols of Cherry Hospital and Dr. R. J. Blackley of the Alcoholic Rehabilitation Center, in their presentations, stressed the importance of community action in the recovery of the alcoholic. A panel discussion on "Sharing, Planning and Development of Programs" concluded the meeting. Below, from left to right, the panel members were: Marshall Abee; Bill Hales, associate director, Charlotte Council on Alcoholism; Worth Williams; Mrs. Margaret Davis, director, New Hanover County Council on Alcoholism; and Dr. James Osberg, deputy commissioner for the eastern region, N. C. Department of Mental Health. (Ed. Note: The discrepancy between the dateline of this issue and that of this report is due to the belatedness of the issue.)

SUMMER SCHOOL COURSES: Summer Studies on Facts About Alcohol will be conducted this year at East Carolina College in Greenville and North Carolina College at Durham. Co-sponsored by the colleges and the Education Division of the N. C. Department of Mental Health, the dates are June 6-16 at E.C.C. and June 12-30 at N.C.C. Both courses are designed for teachers and prospective teachers and carry college credit—three quarter hours at E.C.C. and three semester hours at N.C.C. The third week at N.C.C. will be devoted to the study of mental health in the classroom and family life education.

The fifth annual Summer School of Alcohol Studies will be conducted June 18-23 at the University of North Carolina in Chapel Hill. The sponsors are the Health Education Department of the School of Public Health, University of North Carolina, the Alcoholism Programs of North Carolina, and the Education Division of the Department of Mental Health. While this course does not carry academic credit, it is open to anyone who is interested in alcoholism and other problems associated with the use of alcohol. Last year students attended from the following disciplines or agencies: public health, local alcoholism programs, local law enforcement, social work, hospitals, ministers, and prisons, probation and parole.

A workshop for professional workers in alcoholism and mental health will be conducted July 16-29 at St. Andrews Presbyterian College at Laurinburg. Attendance will be by invitation and limited to thirty people. Plans for the course are incomplete but, tentatively, the subject matter to be covered will include alcohol education, family life education, and general mental health. It is expected that the students will be drawn largely from mental health clinics and alcoholism information centers.

NATIONAL AWARD: The National Council on Alcoholism's annual award for the "most outstanding Alcoholism Information Week program among cities with a population of less than 100,000" was received this year by the Durham Council on Alcoholism, Durham, N. C. The award, presented at the concluding luncheon session of the association's annual meeting held April 11-14 at Flint, Michigan, was accepted in behalf of the Durham Council on Alcoholism by Mrs. Olga Davis, executive secretary. Below, Mrs. Davis proudly displays the award which brought national recognition to Durham.

pitals in the country are in fact admitting alcoholic patients to the general medical floors with the true diagnosis of the patient being clouded by such labels as peripheral neuritis, acute gastritis, etc.

There is some therapeutic benefit in having a specialized alcoholism ward on a general medical floor so that these alcoholic patients may communicate with one another and at times influence one another to follow a program of sobriety such as A.A. and to discuss openly the overall problems of alcoholism without fear of stigma or rejection on the part of those who do not share the problem. In general, the alcoholic patient does not desire to be treated in a psychiatric unit, and he resents being classified as such. Use of the specialized ward on the general medical floor has the advantage of allowing the patients to be seen collectively by a Twelth Step A.A. member whose important message is so vital to the future of the majority of these patients. A disadvantage to the use of the special ward is the stigma which naturally accrues from being placed in a labeled bed in a labeled room.

If one is selective about the admission of the chronic alcoholic to the general hospital and if an adequate screening process is followed where each individual patient is evaluated on his own merits, I feel that all general hospitals can, and should, accept these patients for treatment. The general hospital which would accept the responsibility for caring for such patients not only brings itself closer to the problems of the general community and improves its public relations but also fulfills its total purpose—the care of the sick.

All patients are seen daily by the attending physician on rounds and

The facilities of the general

all patients are given a physical examination by the medical resident assigned to the Alcoholism Clinic. Selective cases are referred to the clinical psychologist for consultation and a consultant psychiatrist utilizes his special skills when needed. In order to bring the best possible care and treatment to the chronic alcoholic patient the skills of various medical specialties may frequently be invoked. Referral to the general surgeon, neurosurgeon, orthopedic surgeon, urologist, dermatologist, or dentist may at times be necessary. Here again is the value of the treatment of the chronic alcoholic in a general hospital where such consultations can readily be obtained. An attempt is made to refer as many patients as possible to the various A.A. groups in the area. The alcoholism clinic social workers interview the various patients and may make referrals to various community resources. Many patients are followed in the outpatient department for prolonged periods of time by the social workers who may do individual counseling, family counseling, or conduct group therapy sessions. Ambulatory patients are encouraged to attend group therapy sessions which can be the beginning of a long course of follow-up therapy on an outpatient basis following their discharge from the hospital.

The City of Worcester is indeed fortunate to have a fine network of facilities to help the chronic alcoholic patient. Numbered among these community resources are the Belmont Home, a rehabilitation center for the homeless and indigent man sponsored by the Worcester Board of Public Welfare; the Catholic Char-

hospital are needed by the alcoholic in his quest for recovery.

ities center, Our Lady of the Way, for the homeless, indigent male; FAITH, Inc., a non-profit, voluntary organization for the rehabilitation of the homeless female alcoholic; and the Worcester County Council on Alcoholism, an affiliate of the National Council on Alcoholism, made up of active community leaders.

Our more than ten years of experience at St. Vincent Hospital with over 4,000 cases has taught us many things concerning the treatment of the alcoholic patient. We have learned that usually our first contact with the alcoholic patient is at the hospital outpatient department or emergency room where he presents himself for treatment. We have reason to believe that the general hospital setting is the most suitable for the initial treatment of the chronic alcoholic inasmuch as the facilities afforded by the general hospital are those first needed by the patient in his quest for recovery. We have found that these patients respond readily and in many cases quite dramatically to merely a few days of hospitalization where, by means of the newer medications now available, the terrible withdrawal symptoms of alcoholism can be effectively combatted.

Certainly prolonged hospitalization is neither necessary or practical. I do not wish to convey the impression that the inpatient care of the alcoholic patient is the only treatment to be given nor that such care is necessarily the most important phase of treatment, but the inpatient care of the alcoholic patient can be the focal point and proving ground for outpatient follow-up treatment of that disease which has no cure and for which relapses can only be prevented by means of a positive program of therapy. Since the disease of alcoholism entails complex etiological factors and is accompanied by social, psychological, and psychophysiological complications, after the physical aspects of the disease are brought under control, attention must be paid to those other factors involved in the illness if effective help is to be given. At our hospital a member of the social service department interviews the patient while he is in the hospital and over the acute stages of illness. A social history is obtained and interviews with other members of the family are arranged to further facilitate the treatment plan. The referral of the homeless man or woman is effected through the above community resources. An attempt is made to refer as many patients as possible to Alcoholics Anonymous and an A.A. sponsor is frequently contacted by the social worker prior to the patient's discharge from the hospital. Many patients who have recovered while following the A.A. program and have had a period of sobriety lasting several years, had their first contact with that organization while undergoing inpatient treatment in our hospital.

In conclusion, I believe that the chronic alcoholic patient can be successfully and effectively treated on an inpatient basis in the community general hospital. I also believe that further community education concerning the true nature of this, the nation's fourth largest public health problem, will create an attitude of acceptance among general hospitals everywhere to do their part.

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for

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—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Almance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

†*Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd.; Phone: 227-6271.

BUTNER—

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Mental Health Clinic,* 102 Church St.; Phone: 786-1181.

DURHAM—

†*Department of Psychiatry, Duke University Medical Center;* Phone: 648-8111, Ext. 3416.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

FAYETTEVILLE—

†*Cumberland County Mental Health Center;* Cape Fear Valley Hospital; Phone: 484-8123.

GASTONIA—

†*Gaston County Mental Health Clinic,* 206 N. Highland St.; Phone: 864-8381.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12.00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* Durwood Howard, Director; P. O. Box 1598; Phone: 919-735-7033.

†*Wayne County Mental Health Clinic,* 715 Ash St.; Phone: 735-4331.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: 273-8281.

†*Family Service Agency;* 1301 N. Elm St.

GREENVILLE—

†*Coastal Plain Mental Health Center,* 1827 West Sixth St.; Phone: 752-7151.

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

HENDERSON—

†*Vance County Mental Health Clinic,* County Home Rd.; Phone 492-1176 or 438-4813.

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 By-pass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

†*Henderson County Health Department;* Phone: 692-4223.

HIGH POINT—

†*Family Service of High Point,* 113 Gatewood Ave.; Phone: 883-1709 or 833-2119.

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

†*Scotland County Mental Health Clinic,* 1304 Biggs St.; Phone: 276-7360.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 919-638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

PINEHURST—

Sandhills Mental Health Center; Box 1098; Phone: 295-6851.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: 633-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

†*Anson County Health Department;* Phone: 694-2516.

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILKESBORO—

**Wilkes County Council on Alcoholism;* 100 Bridge St.; Phone: 919-838-6046.

WILMINGTON—

†*Southeastern Mental Health Center,* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Robert Charlton, Educational Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

†*Department of Psychiatry, Bowman Gray School of Medicine;* Phone: 725-7261.

†*Forsyth County Mental Health Unit,* Seventh and Woodland; Phone: 722-0364.

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